

AGENCY CONSOLIDATED BUDGET REQUEST-FY2006**Bureau of Emergency Medical Services**

This form should be typed or computer generated and accompany ALL competitive grant requests

LIMIT TO 3 ITEMS**Agency Information:**

Name of agency _____ EMS Provider No. _____
Address _____ Phone _____
City _____ County _____ Contact Person _____
Zip Code _____ E-mail _____

Priority One

Item : _____

Priority Two

Item: _____

Priority Three

Item: _____

Units	Unit Price	Total	Local Match	State Share
TOTAL				\$

DEMOGRAPHIC INFORMATION

Demographic information MUST be completed to receive points for geographic parity.

1. Indicate the call volume of the agency last year:

EMS Calls: (ambulance, paramedic, 1st responders) _____ Patients: (Hospitals only) _____

Dispatch Calls: (Dispatch Agencies) _____ Other Calls: _____

2. Indicate the percent of responses to non-residents of the service area. _____

3. Furnish information about your agency:

a. Square miles: _____

b. Type terrain: _____

c. Population: _____

4. Indicate type of service, licensed or designated level.

5. Furnish information about partnerships/collaboration and mutual aid agreements with other agencies. List the agencies:

INITIAL TRAINING AND CONTINUING MEDICAL EDUCATION GRANT JUSTIFICATION FY2006 - CATEGORY 1

Bureau of Emergency Medical Services

This form should be typed or computer generated

Non EMS licensed agencies are eligible for initial dispatch and EMT training only

Agency Information:

Name of agency _____ EMS Provider No. _____
Address _____ Phone _____
City _____ County _____ Contact Person _____
Zip Code _____ E-mail _____

	Units	Price	Total	Local Match	State Share

Current personnel inventory:

Number Level of Personnel

	Dispatchers
	EMT Basic
	EMT Intermediate
	EMT IA
	Paramedic
	Other

Applying agency is: (check one of the following)

_____ Licensed EMS agency
_____ Designated EMS agency
_____ Non licensed agency

Please describe how you will use these monies. Specific information must be given as to exact use of training and CME funds.

Use additional sheets if necessary

TRAINING EQUIPMENT GRANT JUSTIFICATION FY2005 - CATEGORY 2

Bureau of Emergency Medical Services

This form should be typed or computer generated

Agency Information:

Name of agency _____ EMS Provider No. _____
Address _____ Phone _____
City _____ County _____ Contact Person _____
Zip Code _____ E-mail _____

Item Requested:	Units	Price	Total	Local Match	State Share

Justification: (When training equipment is requested, a copy of the manufacturer's information must be attached to application.)

Use additional sheets if necessary

COMMUNICATION EQUIPMENT GRANT JUSTIFICATION FY2005 - Category 3**Bureau of Emergency Medical Services****This form should be typed or computer generated****Agency Information:**

Name of agency _____ EMS Provider No. _____
Address _____ Phone _____
City _____ County _____ Contact Person _____
Zip Code _____ E-mail _____

Item Requested:	Units	Price	Total	Local Match	State Share

ALL COMMUNICATIONS EQUIPMENT MUST BE REVIEWED BY FLOYD RITTER, Bureau Communications Consultant, by January 17, 2005, otherwise your request will not be considered.

Floyd Ritter can be reached at 801 538-3316; email: fritter@utah.gov; or by mail at:
State of Utah, DAS/DITS, 6000 State Office Building, Salt Lake City, UT 84114.

Reference number issued by Floyd Ritter No. _____

When requesting equipment, please include the following:

- a) A description of the current system (including diagrams).
- b) The proposed change (including diagrams).
- c) The reason for proposed change.
- d) Percentage equipment will be used for EMS purposes.
- e) When requesting pagers, the application shall state the number of functional pagers, the number of personnel who carry pagers and the number of personnel per unit.
- f) Date contact was made with Floyd Ritter.

Justification:

VEHICLE GRANT JUSTIFICATION FY2006 - Category 4

Bureau of Emergency Medical Services

This form should be typed or computer generated

Agency Information:

Name of agency _____ EMS Provider No. _____
Address _____ Phone _____
City _____ County _____ Contact Person _____
Zip Code _____ E-mail _____

Vehicles Requested:	Units	Price	Total	Local Match	State Share

Purpose:

☐

Additional Vehicle

☐

Replacement Vehicle

☐

Remount Vehicle

If a replacement vehicle, which vehicle will it replace:

What will be the disposition of the vehicle being replaced:

Justification

The Vehicle Inventory sheet must also be completed by accplicant.

EMERGENCY VEHICLE INVENTORY - Category 4
Bureau of Emergency Medical Service
This form should be typed or computer generated

Agency: _____

Type of Vehicle _____	Make: _____
Age of vehicle: _____	Mileage: _____
Expenses during past year. _____	
General Condition: _____	

Type of Vehicle _____	Make: _____
Age of vehicle: _____	Mileage: _____
Expenses during past year. _____	
General Condition: _____	

Type of Vehicle _____	Make: _____
Age of vehicle: _____	Mileage: _____
Expenses during past year. _____	
General Condition: _____	

Type of Vehicle _____	Make: _____
Age of vehicle: _____	Mileage: _____
Expenses during past year. _____	
General Condition: _____	

DEFIBRILLATOR GRANT JUSTIFICATION FY2006 - Category 5**Bureau of Emergency Medical Services****This form should be typed or computer generated****Agency Information:**

Name of agency _____ EMS Provider No. _____
Address _____ Phone _____
City _____ County _____ Contact Person _____
Zip Code _____ E-mail _____

Item Requested:	Units	Price	Total	Local Match	State Share

Justification:

Please indicate the level of your agency:

_____ Nonlicensed
_____ Designated
_____ Licensed
_____ Other (specify) _____

Please include in the justification how many defibrillators you presently own, the type and the age of each.

EXTRICATION GRANT JUSTIFICATION FY2006 - Category 6**Bureau of Emergency Medical Services****This form should be typed or computer generated****Agency Information:**

Name of agency _____ EMS Provider No. _____

Address _____ Phone _____

City _____ County _____ Contact Person _____

Zip Code _____ E-mail _____

Item Requested:	Units	Price	Total	Local Match	State Share

Complete the number of extrication devices owned by your agency:

Type	How Old
RS 10 Kit:	
Spreader:	
Cutter:	
Ram:	
Other:	

Do any other agencies (i.e. fire, police, rescue) plan to share in the use of the equipment purchased with funding from this grant?

If yes, please list names:

How many EMS runs required extrication in the past year?

State average time to incident requiring extrication:

Justification:

AMBULANCE/RESCUE EQUIPMENT GRANT JUSTIFICATION FY2006 - Category 7

Bureau of Emergency Medical Services

This form should be typed or computer generated

Agency Information:

Name of agency _____ EMS Provider No. _____

Address _____ Phone _____

City _____ County _____ Contact Person _____

Zip Code _____ E-mail _____

Item Requested:	Units	Price	Total	Local Match	State Share

Manufacturer's literature must accompany this grant request.

Justification:

Use additional sheets if necessary

DEMONSTRATION/RESEARCH GRANT JUSTIFICATION FY2006

Bureau of Emergency Medical Services

This form should be typed or computer generated

Agency Information:

Name of agency _____ EMS Provider No. _____
Address _____ Phone _____
City _____ County _____ Contact Person _____
Zip Code _____ E-mail _____

Item Requested:	Units	Price	Total	Local Match	State Share

For Demonstration or research projects, the justification shall be presented in the following format:

PROBLEM: Describe the problem:
OBJECTIVE: Describe the objective in measurable terms as a solution to the problem;
METHOD: Describe the methods for accomplishing the objective with specific time frame, and,
EVALUATION: Describe the evaluation criteria for success in meeting the project objectives and list the personnel who will assist the applicant to assure the integrity of the evaluation.